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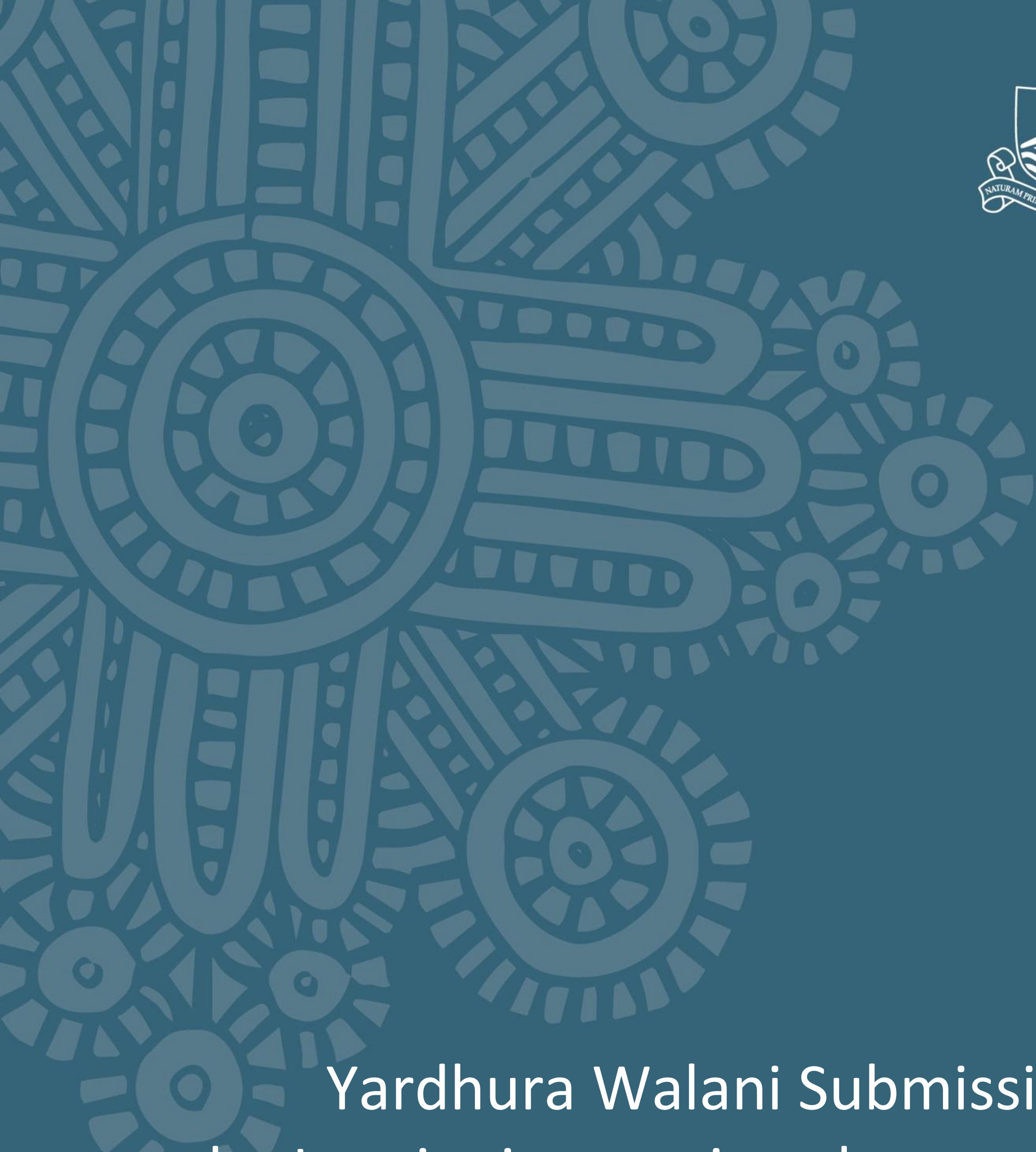

Yardhura Walani Submission to the Inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples

Yardhura
Walani

National Centre for
Aboriginal and Torres Strait Islander
Wellbeing Research

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ABOUT YARDHURA WALANI

Yardhura Walani, the National Centre for Aboriginal and Torres Strait Islander Health and Wellbeing Research, is the largest, and arguably most impactful, Aboriginal and Torres Strait Islander-led and governed health and wellbeing research centre in Australia, housed at the Australian National University (ANU).

Yardhura Walani's research focuses on the most significant health and wellbeing factors that impact Aboriginal and Torres Strait Islander peoples' lives including culture, racism, tobacco, cancer and chronic disease.

This research has informed sustainable and systemic change in the design and delivery of health services, improving practice and services to better serve Aboriginal and Torres Strait Islander peoples.

Our National Centre's success is underpinned by deep community partnerships, with representation from all states and territories, ensuring research agendas are set by community and we build research capacity at grassroots level.

We are Aboriginal and Torres Strait Islander led, governed and host a centre of 55, with almost half (27) Aboriginal and/or Torres Strait Islander researchers and staff. We are home to outstanding Aboriginal and Torres Strait Islander academics and are building a critical mass of Aboriginal and Torres Strait Islander health research leadership.

Our principle is to be in service to Aboriginal and Torres Strait Islander peoples.

Our purpose is to strengthen the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

'Yardhura Walani' is Ngunnawal for 'strong, healthy place', a name gifted to us by Ngunnawal Elders on behalf of the Winanggaay Language Groups, comprising all Ngunnawal families. As the Centre's leadership we are charged with ensuring we honour this meaning, and creating this strong, healthy place for our peoples against the tide of 200 years of oppression and colonial harms.

Of critical importance to the Centre's leadership is honouring the responsibility and mandate we have from giants of the health research space spanning decades, who guide our journey: Aunty Pat Anderson AO, Uncle and Professor Tom Calma AO and the late Aunty and Dr Lowitja O'Donoghue AC CBE DSG, in addition to the over 100 communities we partner with, and our own families and communities we belong to, who put full faith in our talents and abilities.

Our submission to the Inquiry into racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples is evidence based, drawing on the Centre's deep academic and lived expertise in Aboriginal and Torres Strait Islander health and wellbeing. Further, while this Inquiry is framed around racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples, the evidence presented in this submission demonstrates that these harms are more pervasive than unidirectional acts, operating structurally through systems, institutions, and public discourse to shape exposure, outcomes, and lived experience.

INTRODUCTION

RACISM IN AUSTRALIA IS BY DESIGN

Racism in Australia did not develop by accident; it was deliberately embedded into laws, institutions, and social attitudes to justify and reinforce colonial control.

The foundations of racism, including scientific racism, lies in the work of “eminent [discredited] scientists” including Samual Morton who developed the hierarchies of race(1). From the moment of British invasion in 1788, the doctrine of terra nullius was used to deny the existence, land ownership, and sovereignty of Aboriginal and Torres Strait Islander peoples, allowing their displacement without treaty or consent. This legal fiction underpinned violent frontier expansion, land theft, and the exclusion of Aboriginal and Torres Strait Islander peoples from political, economic, and legal systems. Racist beliefs were promoted as “scientific” or moral truths to portray Indigenous peoples as inferior, making oppression appear natural and necessary for building the colonial state (2, 3, 4, 5).

These systems were not incidental. As Australia developed, racism was actively produced and sustained through settler-colonial policy and institutional design. They were deliberately constructed and remain operational through contemporary policy, institutional practice, and public discourse. Paternalism (often framed as protection) and segregation laws controlled where Aboriginal and Torres Strait Islander peoples could live, work, marry, and travel, while government authorities removed children from their families in an attempt to erase Aboriginal and Torres Strait Islander cultures, now known as the Stolen Generations. At the national level, the White Australia Policy restricted non-European immigration to preserve racial hierarchy, hegemony, and economic advantage for white Australians. Together, these systems and policies limited Aboriginal and Torres Strait Islander peoples’ access to education, wages, healthcare, and citizenship rights, creating long-term, intergenerational social and economic inequity. Racism in Australia was intentionally designed, and continued to evolve, to centralise power and resources in the hands of a white dominant group while suppressing others. Goenpul academic Distinguished Professor Aileen Moreton-Robinson describes the Australian state as “white possessive logic” – a system that secures land, resources, and authority for non-Indigenous people while excluding Indigenous sovereignty (6).

Australia denies racism against Aboriginal and Torres Strait Islander peoples exists, by framing persistent inequity as an issue of disadvantage and vulnerability. Blame is placed on individual behaviours rather than seeing inequity rightfully as the result of ongoing structural racism. Government and public institutions have at times acknowledged historical wrongs, often without acknowledging the racist underpinnings (e.g. in the case of the Apology), or insisting racism is confined to the past, and allowing contemporary policies (e.g. disproportionate policing, child removals, and punitive welfare controls) to be portrayed as neutral or necessary. Aboriginal and Torres Strait Islander voices that name racism are frequently dismissed as exaggerating, politicising identity, or refusing to move on, which shifts attention away from peoples lived experience and the sources of systemic harm. This denial is itself a mechanism of racism, functioning to obscure structural causes, delegitimise Aboriginal and Torres Strait Islander lived experience, and maintain existing power structures.

This denial is reinforced by resistance to truth-telling processes, discomfort with acknowledging sovereignty and land theft, and public narratives that prioritise national pride over accountability, making it difficult to make meaningful progress in eliminating the enduring racism faced by Aboriginal and Torres Strait Islander peoples.

RACISM CONSEQUENCES ON HEALTH AND WELLBEING

Racism is recognised as a public health crisis in Australia and internationally (7-11). This evidence establishes racism not only as a pervasive social issue, but as a measurable and preventable driver of disease, distress, and premature mortality.

Racism is endemic in settler-colonial Australia, systematically and deeply embedded across institutions, systems, and structures. A robust evidence base demonstrates the negative and far-reaching consequences of racism on health and wellbeing (12). The health and social inequities seen today for Aboriginal and Torres Strait Islander peoples compared to non-Indigenous people in Australia are not due to biology or race: they reflect effects of settler-colonialism and racism (12). Race is a social construct and does not “cause” disease (13); racial inequities arise through, and are reinforced by, racism (interpersonal, institutional, and structural) (14, 15, 16, 17, 18, 19).

Yardhura Walani has conducted research that informs how exposure to (experiencing) racism is linked with negative health and wellbeing outcomes. The data came from almost 10,000 Aboriginal and Torres Strait Islander peoples participating in Mayi Kuwayu: The National Study of Aboriginal and Torres Strait Islander Wellbeing (20, 21). These findings are based on discrimination and racism measures developed and validated with and for Aboriginal and Torres Strait Islander adults (22). The Mayi Kuwayu data tells us that racism and discrimination have negative consequences for Aboriginal and Torres Strait Islander peoples’ health and wellbeing, across a range of health and wellbeing outcomes (including high-blood pressure, anxiety, poor self-rated general health, high psychological distress, and low self-reported control over life).

SETTLER-COLONISATION IS THE FUNDAMENTAL CAUSE OF RACISM, HATE, AND VIOLENCE DIRECTED AT ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Settler-colonisation is the foundational determinant, shaping ongoing racism, rather than racism appearing in isolation. This reflects Indigenous scholarship that frames racism as a mechanism of ongoing settler-colonisation, not merely a social or behavioural attitude. Racism affects health through pathways including psychosocial stress (e.g. settler-colonial inflicted trauma, racism related vigilance, grief, and cultural disruption), social determinants, health care access and barriers to culturally safe health care. This framework locates harm in ongoing systems and histories. Protective factors central to Social and Emotional Wellbeing (SEWB), such as culture, connection to Country, kinship, and community control, can buffer the impacts of structural racism and support health and wellbeing, but these protective assets are actively eroded as part of coloniality.

Guided by the United Nations Declaration on the Rights of Indigenous Peoples (23), this submission centres Aboriginal and Torres Strait Islander peoples' sovereignty, self-determination, and definitions of health. This framing recognises that racism is not only experienced interpersonally, but is produced and sustained through systems, institutions, and policy design. As such, addressing racism requires approaches that move beyond improving implementation within existing systems, toward identifying and dismantling harmful structures and strengthening Indigenous-led systems of care (24). This approach recognises the limitations of applying conventional policy and implementation frameworks within colonial systems and instead orients action toward structural transformation and (re)building (25).

Case Study 1

SETTLER-COLONISATION AND TOBACCO: A DRIVER OF DISEASE AND INEQUITY

Commercial tobacco remains the leading cause of preventable harm for Aboriginal and Torres Strait Islander peoples in Australia (26, 27). It contributes to high levels of disease, disability, and early death. To understand tobacco-related harm, we must look beyond individual behaviour and recognise the broader systems that have shaped exposure, dependence, and health outcomes. Tobacco use among Aboriginal and Torres Strait Islander peoples is not accidental. It reflects a history of settler-colonisation, dispossession, exclusion from economic and education systems, and ongoing structural racism (25, 28, 29). It is also sustained by a commercial industry that continues to profit from addiction and harm (25, 30).

This case study demonstrates that tobacco-related harm is not simply a public health issue. It is a matter of racial justice and speaks directly to the nature, prevalence, and impacts of structural racism experienced by Aboriginal and Torres Strait Islander peoples over time (28, 29, 31).

What does this case study tell us about racism, hate, and violence directed at Aboriginal and Torres Strait Islander peoples?

The story of commercial tobacco in Aboriginal and Torres Strait Islander communities begins with settler colonisation. People were removed from their lands, disrupting systems of culture, economy, and governance that had sustained health and wellbeing for tens of thousands of years. At the same time, Aboriginal and Torres Strait Islander peoples were excluded from the emerging cash economy and denied access to education and opportunity (29).

Within this context, tobacco was systematically embedded through ration provision on reserves and missions and was additionally used as payment for labour instead of cash. This process embedded dependence, normalised tobacco use, and linked survival to the consumption of harmful products. Those practices were violent, where policies and the systems through which they were implemented create conditions that lead to long-term harms (29).

The impacts of these systems are still visible today (25, 28, 32). Tobacco use remains a major contributor to premature death. Evidence shows that around half of deaths among Aboriginal and Torres Strait Islander adults aged 45 and over may be caused by smoking, and over one-third of all Aboriginal and Torres Strait Islander deaths attributable to tobacco use (32). Tobacco affects the entire body, contributing to cardiovascular disease, respiratory illness, cancer, and complications from chronic conditions such as diabetes (33). The majority of deaths among people who smoke are caused or worsened by tobacco use, reflecting its pervasive impact on health (33). This demonstrates the scale and severity of harm caused by systemic inequities, rather than isolated individual choices (25, 28, 33).

Despite this, tobacco products remain widely available and legally sold. This reflects systems failure to provide care and to prevent, regulate, and respond to known and ongoing harms. Aboriginal and Torres Strait Islander peoples continue to experience higher exposure to tobacco-related harms, while also facing the ongoing effects of economic exclusion, lower access to education, and structural disadvantage. These conditions shape both the uptake

and continuation of smoking.

At the same time, the tobacco and nicotine industry continues to actively sustain addiction and expand markets in ways that exploit structural inequities, particularly among populations disproportionately impacted by colonisation (29, 34). Narratives such as “harm reduction” are often used to present new products as solutions, while maintaining dependence and expanding markets. This pattern highlights how racism operates structurally: not only through direct acts of hate or violence, but through policy settings, regulatory gaps, and institutional inaction that allow harm to persist (25, 28, 34).

Public discussion of tobacco use has frequently focused on individual responsibility. This has the effect of shifting attention away from the systems that create and sustain harm. Language that describes Aboriginal and Torres Strait Islander peoples as “vulnerable” can further obscure the role of power, policy, and industry, reinforcing deficit narratives rather than addressing structural causes (34, 35).

Despite these ongoing structural harms, Aboriginal and Torres Strait Islander peoples have demonstrated sustained resistance to commercial tobacco. This is reflected in high intentions to quit, reduced consumption, and shifting smoking practices, particularly where Indigenous-led programs and community-controlled approaches are in place (36, 37).

These consequences extend beyond individuals. Tobacco-related illness and early death affect families and communities, leading to loss of Elders, disruption of cultural continuity, and ongoing grief. These impacts accumulate across generations, reflecting the enduring nature of structural racism and the cumulative burden of racism on health and wellbeing (28, 34, 35).

What must be done?

Addressing tobacco-related harm requires structural reform, strong regulation, and sustained investment in Aboriginal and Torres Strait Islander-led solutions. It also requires a shift in narrative, from individual responsibility to systemic accountability and actions (25, 29). This framing is reinforced through public and media narratives that isolate behaviour from its structural context, contributing to stigma and misrepresentation.

At a structural level, this means recognising the commercial tobacco and nicotine industry as a driver of disease and inequity. Continued reliance on a product that is known to cause widespread harm is incompatible with a commitment to health equity. There is a clear need to reduce and ultimately phase out the supply of commercial tobacco products, while preventing the expansion of new nicotine markets (25, 29, 38).

This must occur alongside action on the broader determinants of health. The historical exclusion of Aboriginal and Torres Strait Islander peoples from the cash economy and education systems continues to shape health outcomes. Addressing tobacco-related harm therefore requires investment in economic participation, access to education, and community development, as well as recognition of the central role of land, culture, and sovereignty in health and wellbeing (25, 29, 38).

Aboriginal and Torres Strait Islander leadership is critical. Policies and programs are most effective when they are designed, led, and delivered by communities themselves. Strengthening community-controlled health services and supporting local decision-making are essential components of an effective response. These approaches reflect evidence-based initiatives that reduce harm and counter the impacts of racism (29).

There is also a need to strengthen regulatory and policy frameworks to limit industry influence. This includes protecting public health policy from commercial interests, increasing transparency, and actively countering misinformation. Ensuring that systems can effectively identify, respond, and adapt to harmful practices is central to improving accountability and care (25, 28, 38).

At the individual level, people who smoke must be supported to quit in ways that are culturally safe and accessible. Evidence shows that quitting at any age leads to significant health benefits. However, support must go beyond clinical interventions. It should be integrated with broader efforts to support social and emotional wellbeing, strengthen cultural connections, and build community resilience (29, 39, 40).

Community-led health promotion plays a critical role in this work. Aboriginal and Torres Strait Islander-led campaigns provide culturally relevant messaging, support informed decision-making, and actively challenge harmful narratives and industry influence. These actions align with a strong evidence base demonstrating that Indigenous-led, structurally focused approaches are the most effective in reducing harm and improving health outcomes (28, 29).

Case Study 2

PSYCHOLOGICAL IMPACTS OF RACISM

Mayi Kuwayu: the National Study of Aboriginal and Torres Strait Islander Wellbeing (the Mayi Kuwayu Study) is an Aboriginal and Torres Strait Islander-led and -governed cohort study founded on years of extensive community engagement and conducted in partnership with Aboriginal and Torres Strait Islander communities and organisations (21). The Study survey was designed by and for Aboriginal and Torres Strait Islander peoples, measuring wellbeing in ways that matter to Mob (41). Understanding culture and its relationships to wellbeing is at the core of the Mayi Kuwayu Study.

Communities identified racism as a major health and wellbeing risk, so the Mayi Kuwayu Study has measured the prevalence of experiences of discrimination and racism, using validated instruments, since the Study commenced in 2018.

What does this case study tell us about racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples?

Analysis has revealed the extremely high percentage of Aboriginal and Torres Strait Islander adults who have experienced discrimination and racism and has begun to build a picture of the magnitude of the impact of discrimination and racism on health, and the magnitude of racism's contribution to health inequity (the 'gap').

Research by the Mayi Kuwayu study team, published in the Lancet (12) found:

- Two in three Aboriginal and Torres Strait Islander adults (64.6%) have experienced any of the eight types of everyday (interpersonal) discrimination measured by the Study.
- High/very high psychological distress is almost three times as likely among those who experienced any (compared to no) everyday discrimination (prevalence ratio=2.77).
- Everyday discrimination could explain up to half (49.3%) of the total burden of high/very high psychological distress experienced by the Aboriginal and Torres Strait Islander adult population.

Looking at its contribution to health inequity, the team found that everyday racial discrimination could explain almost half (47.4%) of the overall 'gap' in psychological distress between Aboriginal and Torres Strait Islander and non-Indigenous people.

This means that eliminating everyday racial discrimination could halve the 'gap' in the prevalence of high/very high psychological distress. These estimates are likely to be conservative. Noting that the Study measured only eight types of interpersonal discrimination, and that there can be substantive negative impacts on wellbeing even at lower levels of psychological distress, the total contribution of all types of interpersonal discrimination, and all experiences of structural racism, to wellbeing could be much greater.

These findings show that racism:

- is real, and common;
- has substantial negative impacts on individuals and the population; and,
- is a key contributor to the 'gap' in wellbeing.

What must be done?

The evidence presented in this case study is a conservative estimate of racism's harms to psychological wellbeing. These findings reinforce the imperative to combat interpersonal discrimination and racism, and the underpinning systems that maintain structural racism. To eliminate racism, action is required on an individual level through to institutional and systems levels. This includes:

1. Embedding Truth Telling and cultural safety: at the individual, institutional and structural levels, and in systems through policy and regulation. See Yoorrook (42).
2. Governance: at senior institutional and systems levels, Aboriginal and Torres Strait Islander decision making and authority is required. Many organisations focus on bringing in junior Aboriginal and Torres Strait Islander staff who have limited ability to influence or set organisational policy. Influencing and guiding organisational executives and policy is required (43).
3. Accountability and monitoring: at institutional and systems levels, where all forms of racism are identified, action to address racism are required that use a systems thinking approach. There is a need for systems that listen and learn. In addition, monitoring systems are required to establish baseline data and monitor trends over time and to identify the impact of action (43, 44).
4. Expect resistance, including violent resistance and reversion, and plan accordingly. Our research, complementing that of leading scholars, highlights that the call for justice and the pursuit of structural change concerning racism is often met with (re)active racism, resistance, and retribution as dominant systems and groups seek to maintain and entrench power (17, 45, 46).

Practical Resources

Do the Racism Check Up: for non-Indigenous people and organisations, to reflect on your own attitudes and actions, access resources, support positive change and help end racism.

Engaged ANU | Ending racism: Check up

Watch the Ending Racism video: Watch the video to hear from Aboriginal and Torres Strait Islander peoples about the impacts of discrimination and their visions for a world without racism.

Ending Racism. | Videos & Movies on Vimeo

Visual storytelling: Learn more about the impact of everyday discrimination on psychological distress for Aboriginal and Torres Strait Islander peoples.

Engaged ANU | Ending racism.

Recommendations, implementation tips, and useful resources:

RACGP - Chapter 1 | Health impacts of racism, and

RACGP - AJGP (Australian Journal of General Practice)

Case Study 3

SOCIAL AND POLITICAL DISCOURSES THAT INCITE RACISM E.G. THE REFERENDUM

Yardhura Walani was commissioned by the Department of Health and Aged Care to provide information about the mental health and wellbeing needs of Aboriginal and Torres Strait Islander peoples in the lead up to the Voice to Parliament Referendum, and to monitor wellbeing over this period. Given the findings of increases in racism exposure and decreases in wellbeing, further funding was provided in the Federal budget to continue monitoring for 18 months following the Referendum.

There were statistically significant and substantial increases in the percentage of all Aboriginal and Torres Strait Islander adults experiencing everyday discrimination, discrimination in health care, and vicarious racism, in the lead up to and/or following the Referendum, compared to earlier periods (47).

In the year preceding the Referendum campaign, 66.4% of adults had ever experienced everyday discrimination, 41.0% had ever experienced discrimination in healthcare, and 71.5% had ever experienced vicarious racism. In the 18 months following the Referendum, these percentages increased significantly and meaningfully to 74.4%, 51.8%, and 78.8% respectively.

Over this same period, significant and substantial deterioration was observed across indicators of wellbeing, including an increase in psychological distress prevalence (39.5% to 42.9%) and an increase in feeling torn between cultures (24.9% to 34.1%), and decreases in good general health (65.1% to 60.3%), high happiness (86.3% to 82.9%), high life satisfaction (71.8% to 67.6%), multiple measures of family and community support.

What does this case study tell us about racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples

The monitoring of racism and wellbeing around the Voice Referendum is an exemplar of negative social discourses surrounding political imperatives: in this case, the public debate and discourse surrounding Aboriginal and Torres Strait Islander peoples' explicit representation through an advisory body enshrined in the constitution. The discourses around the Referendum incited racism, amplified existing racism and stress, were re-traumatising, and threatened the identity of Aboriginal and Torres Strait Islander peoples, causing long-lasting health and wellbeing harms.

Eighty-four Aboriginal and Torres Strait Islander people attended focus groups across six sites in April 2023, around the time of the launch of the Referendum campaign. The impacts of discourses around the Referendum, and stress related to the Referendum, were described as far-reaching, massive, and already occurring. Particular concern was raised around mental health and wellbeing impacts of racism exposure among youth. Participants expected these elevated levels of racism exposure, and associated negative impacts, to persist well beyond the outcome of the Referendum vote.

Participants described an increase in frequency and intensity of experiences of racism as a result of discourses around the Referendum. They reported an increase in experiences of direct forms of racism (i.e. between persons) and vicarious forms (i.e. overhearing comments or through media), describing experiences of racism as more intense and "more in my face" in the lead up to the Referendum. Participants foreshadowed that the "racism will become worse the closer it [the Referendum] gets."

Participants described the burdens of constantly thinking about and preparing for racism, monitoring and controlling any responses or reactions to these experiences. One participant said, "I've got to prepare myself because I'll go through what's going to happen if you hear this and hear that ... If there's something that's going to impact me negatively, do I just walk away? But then again...if I don't say anything, am I just appeasing to what could be racism or discrimination?"

Participants described their perceptions of increases in racism prevalence any time issues about Aboriginal and Torres Strait Islander peoples are in the public forum: "Whenever the word Aboriginal Indigenous people are put in the news it's mostly bad, always reporting on the bad side of us, and so when we are in the spotlight a lot of us just think oh here we are again and cop it."

These findings demonstrate that media and public discourse are not neutral. They actively shape the prevalence, intensity, and distribution of racism, including through vicarious exposure. Patterns of reporting that disproportionately emphasise deficit, controversy, or harm when Aboriginal and Torres Strait Islander peoples are in the public spotlight contribute to cumulative, population-level harm. This positions media and public discourse as active structural drivers of racism, rather than passive reflections of public opinion.

What must be done?

There is an urgent need for action against all forms of racism and discrimination, across all settings and institutions. Governments, politicians, media, and public organisations must be accountable for action.

The increases in racism prevalence identified through this study occurred within a broader context of additional current events at national, local, family, and interpersonal scales that have affected the lives of Aboriginal and Torres Strait Islander peoples. Various combinations of these events and discourses are likely to have contributed to the observed rises in racism prevalence; regardless of the cause/s, the increasing racism prevalence alongside concurrent declines in wellbeing are a major concern.

It is critical to note that these findings in no way provide any justification for not pursuing structural change (including progressing truth-telling and reconciliation):

> "The racism, discrimination, and associated health harms observed over the Referendum period and following do not represent justifications for not pursuing structural change designed to eliminate racism or address injustices suffered by Aboriginal and Torres Strait Islander peoples. Justice must be pursued: this is a fundamental determinant of the health and wellbeing of Aboriginal and Torres Strait Islander peoples, families, and communities" (47).

To support enactment of Indigenous rights to proceed with minimal harm, politicians and the media must commit to truth-telling and respectful discourse. The preservation of high levels of health and wellbeing among Aboriginal and Torres Strait Islander adults in the face of escalating stressors and racism in the lead up to and following the Referendum are testament to the strength of Aboriginal and Torres Strait Islander peoples and cultures. There is an urgent need for additional measures to support self-determination and holistic health and wellbeing for Aboriginal and Torres Strait Islander peoples, families, and communities.

Case Study 4

RACISM IN THE WORKPLACE

Systemic and structural racism is deeply embedded across society, including across workplaces, and no profession is exempt. Racism persists even in organisations that value diversity, because structural power imbalances, not individual merit or intent, shape outcomes.

This case study refers to evidence from three separate reports (two directly involving the Australian National University, within which we are located), that estimate the prevalence of racism experienced by Aboriginal and Torres Strait Islander peoples across workplaces, including universities. Racism and culturally unsafe practices are widespread and systemic, negatively impacting health and wellbeing, and increasing colonial load. This colonial load is structural, cumulative, and systematically unrecognised within institutional systems and includes the additional expectations, pressures, and emotional labour placed on Aboriginal and Torres Strait Islander peoples requiring them to educate, support, or represent their culture(s) in predominantly non-Indigenous settings. This colonial load is not incidental, it is produced through institutional design, workload distribution, and leadership failure. These demands also disproportionately impact professionally and personally for Aboriginal and Torres Strait Islander employees.

What does this case study tell us about racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples?

Gari Yala – Speak the Truth: Centering the experiences of Aboriginal and/or Torres Strait Islander Australians at work:

- The Gari Yala (Speak the Truth) report (48) shows that racism remains a significant feature of Australian workplaces for Aboriginal and Torres Strait Islander employees, manifesting through both interpersonal racism (such as unfair treatment, racial slurs and appearance-based comments) and institutional racism (including lack of cultural safety, weak organisational support and limited Indigenous representation).
- More than a third of respondents reported experiencing unfair treatment or racial slurs, 59% encountered appearance racism, and 28% described their workplaces as culturally unsafe. Indigenous employees felt pressure to manage their identity, work harder to prove competence, or shoulder additional unpaid cultural labour.
- Workers experiencing racism, high identity strain or cultural load reported lower wellbeing and job satisfaction and are two to three times more likely to intend to leave their employer.

Racism@Uni Report:

- The Racism@Uni survey – covering 42 out of 43 Australian universities and over 76,000 staff and student participants – found that racism is a widespread, systemic problem (49, 50).
- Aboriginal and Torres Strait Islander respondents reported among the highest rates of racism, with about 30% of Indigenous students and nearly half of Indigenous staff encountering racism.
- Most respondents who experienced racism also reported negative impacts on their wellbeing, sense of belonging, and academic or career outcomes.

- The survey revealed that racism often manifests through everyday interactions and entrenched institutional biases: for Indigenous staff and students this frequently means heavy cultural and service loads, tokenism, feeling unable to speak freely without backlash, and a pervasive lack of cultural safety.
- Notably, nearly half of staff who experienced racism indicated that a senior university leader had been involved in at least one incident, highlighting serious leadership accountability gaps.
- Many affected staff and students (especially Aboriginal and Torres Strait Islander peoples and other marginalised groups) lack trust in formal complaint processes and often avoid using them, perceiving these systems as ineffective.

Nixon Review at the Australian National University (ANU):

- The Nixon Review (51) found Aboriginal and Torres Strait Islander staff and students experience systemic marginalisation at ANU, reflecting broader University-wide cultural and accountability failures.
- Drawing on extensive interviews and submissions, Indigenous participants described recurring patterns of tokenism, heavy service burdens, a lack of cultural safety, and barriers to meaningful support, alongside frustration that their expertise is often sought symbolically but ignored in decision-making.
- Indigenous students reported having to actively seek assistance, sometimes through informal or self-organised means, only to encounter institutional resistance, while staff highlighted how unrecognised service work and cultural labour compound stress and exclusion.

These experiences intersect with the wider findings of racism, bullying, weak accountability of leadership and ineffective complaints processes, contributing to diminished wellbeing, loss of trust, and disengagement from institutional life. The Review emphasises that, despite these experiences, Aboriginal and Torres Strait Islander staff and students remain deeply committed and continue to bring critical knowledge and leadership to the University. These findings reinforce that racism within institutions is not incidental, but produced and maintained through organisational structures, leadership practices, and accountability failures.

What must be done?

As an Aboriginal and Torres Strait Islander led and governed centre within a colonial institution, we continue to demonstrate leadership in addressing these issues despite the structural constraints within which we operate. These experiences reflect broader institutional and system-level failures, not a failure of Aboriginal and Torres Strait Islander leadership. We are not immune to racism in the workplace, and we experience this at the individual, community and systems level. Addressing this requires coordinated, system-level action within our workplace and across institutions more broadly. Drawing on consistent findings across all three reports, action is required to:

- Commit to systemic reform led by accountable leadership, recognising that the most recent 2023 Indigenous Strategy Annual Report from Universities Australia found that, although all institutions reported Indigenous strategies, explicit commitments to anti-racism were the least commonly articulated within Indigenous workforce strategies

(50).
- Embed culturally safe and accessible support and reporting mechanisms; and
- Meaningfully centre Aboriginal and Torres Strait Islander voices and leadership in decision-making. As an example, ANU is one of the eight academic institutions that did not have an Indigenous position at Pro Vice-Chancellor (PVC) Indigenous equivalent or higher.

Together, these actions reflect a shift from symbolic inclusion to structural accountability. These findings demonstrate that meaningful change depends on structural reform, sustained investment, and Aboriginal and Torres Strait Islander leadership at all levels of decision-making.

The Racism@Uni report findings call for sweeping, systemic reforms led by accountable university leadership: measures such as establishing genuinely culturally safe, accessible support and reporting mechanisms, meaningfully engaging Indigenous knowledge and leadership in decision-making, and fundamentally strengthening diversity and accountability at the top. These proposed measures are deemed essential to tackle entrenched racism and rebuild trust, wellbeing and inclusion in Australia’s universities.

The Nixon Report found that improving outcomes requires clear accountability for harmful behaviour, culturally safe and accessible support structures, genuine engagement with Indigenous voices, and systemic reform to embed equity, respect and inclusion across ANU.

Gari Yala – Speak the Truth report demonstrated that racism is reduced and outcomes improve in organisations that genuinely commit to Indigenous inclusion. Organisations with anti-discrimination training and formal racism complaint procedures show roughly half the rates of unfair treatment and racial slurs, while active, Indigenous-led initiatives are associated with lower racism, stronger cultural safety and reduced attrition, underscoring that systemic, well-resourced action can meaningfully transform Indigenous experiences of work.

Case Study 5

CANCER AND COLONISATION — EVIDENCE OF RACISM AND SYSTEM-PRODUCED HARM DIRECTED AT ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES THROUGH THE CANCER CONTINUUM

Background and context

Cancer is the leading cause of death for Aboriginal and Torres Strait Islander peoples in Australia. Aboriginal and Torres Strait Islander peoples experience higher cancer incidence and mortality, are more likely to be diagnosed with cancers that are preventable or amenable to early detection, and experience poorer outcomes across the cancer continuum (52).

These inequities are not explained by biological differences or individual behaviour. Evidence shows they are driven by the design and operation of health systems, screening, and data systems that do not equitably meet the needs of Aboriginal and Torres Strait Islander peoples. Colonisation, and its ongoing effects on culturally safe access, workforce distribution, service delivery models, and data governance, remain central determinants of these outcomes. Cancer mortality is declining across Australia, whilst increasing for Aboriginal and Torres Strait Islander peoples (52). This diverging trend is consistent with a system that benefits some and harms others. Cancer inequities represent one of the clearest examples of how structural racism translates into measurable, preventable harm at a population level.

This case study demonstrates how racism directed at Aboriginal and Torres Strait Islander peoples operates structurally, through policy and program design that systematically leaves Aboriginal and Torres Strait Islander peoples carrying avoidable risk and loss, resulting in predictable and preventable inequities in cancer outcomes. It also identifies actions that can reduce harm, particularly when Aboriginal and Torres Strait Islander leadership and culturally safe workforce-enabled pathways are embedded.

What does this case study tell us about racism, hate and violence directed at Aboriginal and Torres Strait Islander peoples?

This case study shows that racism directed at Aboriginal and Torres Strait Islander peoples primarily operates as structural and institutional harm, rather than as isolated interpersonal acts or individual attitudes.

Structural racism is evidenced where apparently neutral cancer screening policies and eligibility criteria fail to account for unequal cancer risk, unequal access to services, and the structural conditions shaping both. These design choices systematically fail Aboriginal and Torres Strait Islander peoples, even where overall population outcomes improve.

Institutional racism is demonstrated where national programs deliver population-level benefits but continue to produce delayed benefits for Aboriginal and Torres Strait Islander peoples, with limited mechanisms to detect, report, and rectify inequitable outcomes at the rate required.

Violence, in this context, is evidenced as system-produced, preventable harm: avoidable illness, avoidable invasive treatment, and avoidable death that occur when effective prevention and early detection are delayed for Aboriginal and Torres Strait Islander peoples relative to others.

This case study does not rely on evidence of interpersonal hate. Rather, it demonstrates how racism and violence are enacted through systems that fail to deliver timely and equitable care.

Example 1: Cervical cancer screening-inequitable elimination as evidence of racism and preventable harm

Australia has committed to eliminating cervical cancer as a public health problem (53). Elimination is commonly defined as a sustained incidence below four cases per 100,000 women. However, modelling evidence demonstrates that this goal is not projected to be achieved equitably (54).

Under current vaccination and screening conditions, cervical cancer elimination for Aboriginal and Torres Strait Islander women is projected to occur more than two decades later than for Australian women overall. This delay is primarily attributed to longstanding inequities in screening access and follow-up, rather than differences in HPV exposure or biology. This is in the context of a National Cervical Screening Program that has been operational since 1991.

Importantly, the modelling shows that increasing HPV vaccination coverage alone does not materially accelerate elimination for Aboriginal and Torres Strait Islander women. By contrast, the factors that meaningfully alter elimination timelines are improvements in screening initiation (reducing the number of women who have never been screened), timely re-attendance, and appropriate follow-up care.

This evidence demonstrates that inequity in cervical cancer outcomes is produced by health system access and pathway design (54, 55). The consequences of this inequity are not abstract: where elimination is delayed, Aboriginal and Torres Strait Islander women experience preventable cancers, unnecessary invasive treatment, and avoidable mortality for much longer than other Australians. These harms are foreseeable and preventable. Failure to act on this evidence reflects a system-level tolerance of inequity, rather than a lack of available solutions.

Accountability for these inequities has also been limited by data system failures (55). Official reporting has identified longstanding limitations in national cervical screening data, including incomplete identification of Aboriginal and Torres Strait Islander peoples (56). Despite these limitations being well documented for many years, governments and key health system leaders have failed to adequately implement evidence-based solutions. This persistent and well-documented inaction constitutes a form of structural racism, allowing avoidable inequities to remain unmeasured, unaddressed, and institutionally tolerated. These limitations reduce the ability of governments and program managers to routinely measure participation, outcomes, and inequities at a national level, and weaken accountability for equitable program performance.

Together, these factors provide clear evidence of racism directed at Aboriginal and Torres Strait Islander peoples operating through a national screening program: delayed benefit, preventable harm, and insufficient visibility to prompt timely correction.

Example 2: Lung cancer screening-evidence of structural racism in eligibility design

The eligibility criteria of Australia’s National Lung Cancer Screening Program provides a further example of racism directed at Aboriginal and Torres Strait Islander peoples through program architecture, in this case through selecting "sameness" and "administrative simplicity" over equity (57).

Lung cancer is the most common cancer and the leading cause of cancer deaths for Aboriginal and Torres Strait Islander peoples (52). Aboriginal and Torres Strait Islander peoples are more likely to be diagnosed with lung cancer at younger ages and experience poorer outcomes.

Despite this, the screening program adopted the same age eligibility criteria for Aboriginal and Torres Strait Islander peoples as for the general population, following the removal of an earlier proposal for lower age thresholds that reflected higher and earlier risk. This decision was justified on the basis of simplicity and consistency.

Published policy analysis has described this as a shift from equity (fairness) to equality (sameness) noting that treating populations with unequal risk and unequal access as though they are the same predictably entrenches inequity. Neutral eligibility rules, when applied to unequal contexts, unevenly distributes benefit and disadvantage to those at greatest risk.

This is evidence of structural racism directed at Aboriginal and Torres Strait Islander peoples operating through policy design, rather than through individual intent.

What must be done?

The actions below align with existing national commitments, including the Australian Cancer Plan (58) and the NACCHO Aboriginal and Torres Strait Islander Cancer Plan (59). Both plans explicitly recognise that Aboriginal and Torres Strait Islander peoples experience disproportionately worse cancer outcomes, identify structural and institutional racism as contributing factors, and commit to equity-designed systems, Aboriginal and Torres Strait Islander leadership, culturally safe care, and improved accountability.

The evidence presented in this case study demonstrates that these commitments have not been implemented with sufficient authority, consistency, or enforceability to prevent ongoing harm. The problem is therefore not the absence of policy direction, but institutional failure to operationalise and be held accountable for delivering on existing plans.

Structural and institutional action

1. Cancer screening programs must be explicitly designed for equity, with eligibility criteria and delivery pathways that reflect differential risk and access rather than administrative simplicity.
2. Aboriginal and Torres Strait Islander leadership and decision-making authority must be embedded across program design, implementation, evaluation, and governance.
3. Data systems must reliably identify Aboriginal and Torres Strait Islander peoples and support routine equity reporting. Without this, inequities will persist without being detected or addressed. Failure to do so should be treated as a breach of program accountability rather than a technical limitation.
4. Aboriginal and Torres Strait Islander data governance and sovereignty should be embedded within cancer screening data systems, ensuring that Indigenous peoples have authority over how data are collected, interpreted, and used to drive accountability and improvement.
5. Cancer screening programs must include formal accountability mechanisms that automatically mandate review and corrective action when inequitable participation,

follow-up, or outcomes are identified, rather than treating inequity as an acceptable program characteristic and inevitable.

Clinical and service action

1. Aboriginal and Torres Strait Islander health workers and practitioners must be resourced as essential personnel for screening delivery, follow-up, and navigation, not treated as optional or supplementary roles.
2. Services must deliver culturally safe care, support informed choice and continuity, and recognise that disengagement from screening often reflects prior system harm rather than individual preference.

Conclusion

This case study provides clear evidence that racism directed at Aboriginal and Torres Strait Islander peoples operates through the design of cancer screening systems and the failure of accountability mechanisms to ensure equitable access and outcomes. Delayed cervical cancer elimination, inequitable lung cancer screening eligibility, and longstanding data gaps demonstrate how neutral-appearing systems can produce predictable and preventable harms. These findings demonstrate how policy decisions that prioritise administrative simplicity over equity can systematically exclude Aboriginal and Torres Strait Islander peoples from timely access to life-saving interventions, reinforcing existing inequities in cancer outcomes.

Evidence also shows that equitable outcomes are achievable when screening programs are redesigned around equity, Indigenous leadership, culturally safe service models, and a strong Aboriginal and Torres Strait Islander health workforce. These actions are necessary to prevent ongoing harm and to meet national commitments to equity in cancer outcomes. Across the cancer continuum, these patterns demonstrate that inequities are not incidental, but produced through policy, program (re)design, and system inaction, resulting in preventable harms for Aboriginal and Torres Strait Islander peoples.

CONCLUSION & RECOMMENDATIONS

Racism, hate and violence experienced by Aboriginal and Torres Strait Islander peoples is systemic, enduring and structurally produced, rather than isolated incidents or individual failures. The evidence presented in this submission shows that these harms are rooted in colonisation and sustained through contemporary policies, institutions, workplaces, commercial systems, and public and political discourse.

Drawing on Aboriginal and Torres Strait Islander-led research, this submission establishes that racism contributes substantially to psychological distress, chronic disease, premature mortality and intergenerational harm. The case studies highlight how racism is frequently normalised, denied, or reframed as neutral practice, enabling harm to persist while limiting accountability.

Yardhura Walani, as an internationally renowned Aboriginal and Torres Strait Islander research centre at the Australian National University is not exempt from these experiences and harms. We exist and thrive in spite of this. We have contributed to this submission because of the profound and direct impact these issues have on us and Aboriginal and Torres Strait Islander communities and peoples.

This Inquiry provides a critical opportunity to frame the contemporary operation of racism, hate, and violence as ongoing tools of colonisation, enacted by a settler-state, and matters of structural failure requiring structural solutions. Reform must be systemic, sustained, grounded in truth-telling, evidence, accountability, self-determination, and led by Aboriginal and Torres Strait Islander peoples.

Across these case studies, a consistent pattern emerges: racism is structurally produced, institutionally maintained, and insufficiently addressed through current systems. The following recommendations respond directly to this evidence and are practical and implementable within existing policy and regulatory frameworks. Failure to act will result in continued, preventable harm.

KEY RECOMMENDATIONS

These recommendations are not aspirational appeals or requests for moral recognition. They represent clear, enforceable obligations grounded in Aboriginal and Torres Strait Islander sovereignty, authority, and lived expertise. They articulate how structural racism must be dismantled and how settler-colonial harm must be addressed. The responsibility for implementation lies with governments, institutions, and systems that continue to benefit from racism.

Priority Area	Key Actionable Recommendations	Focus
Structural/System level/Institutional		
Recognise racism as a public health emergency	Formally recognise racism and settler-colonial harm as a public health emergency, supported by national and international evidence demonstrating its direct contribution to health inequity and premature mortality; shift policy	Government, policy frameworks

	framing from "disadvantage" and “vulnerability” to structural racism as a root cause.	
Recognise colonisation as the upstream determinant	Explicitly acknowledge colonisation and ongoing colonial structures as the foundational upstream cause of racism, hate and violence, and require all policy, legislative, and program responses to explicitly identify and respond to colonial harms as core determinants; which requires policy reform to address these as urgent health determinants.	Policy design, legislation
Aboriginal and/or Torres Strait Islander leadership and authority	Embed Aboriginal and Torres Strait Islander peoples as decision-makers with real authority across boards, the executive, committees and governance systems.	Governance, institutions
Indigenous Data Sovereignty (IDSov)	Governments, institutions, and data-related entities to ensure control of Aboriginal and Torres Strait Islander data by Aboriginal and Torres Strait Islander peoples; Governments maintaining control of Indigenous data is a racist act in itself and the Productivity Commission has made recommendations about how to enact IDSov that have not been responded to or implemented under Priority reform four of the Closing the Gap refresh in the last six years. Implement IDSov principles and Indigenous Data Governance frameworks across all Governments, institutions, and data-related entities, recognising Aboriginal and Torres Strait Islander peoples’ inherent right to own, control and govern data about their communities, ensuring it reflects their priorities and supports self-determination. Establish the Bureau of Indigenous Data as an independent Indigenous government entity as recommended by the Productivity Commission.	Government, Institutions, workplaces, policy frameworks
Leadership accountability	Introduce independent, enforceable accountability mechanisms for racist behaviour across all institutions and workplaces, including at senior leadership levels, with transparent reporting, time-bound	Senior leadership

	action, and clear consequences for inaction.	
Culturally safe reporting systems	Establish culturally safe, trauma-informed, trusted reporting, and support mechanisms that provide protection from retaliation, across all institutions and workplaces.	Institutions, workplaces
Workplace and institutional reform	Acknowledge and address tokenism, unrecognised cultural labour, service overload and lack of cultural safety; properly resource Aboriginal and Torres Strait Islander expertise.	Institutions, workplaces
Social and political discourse accountability	Treat racist public and political discourse as structural violence, with clear, enforceable accountability mechanisms for individuals and organisations, including defined penalties for breaches and effective safeguards during high-risk debates at all levels. This must include action to address systemic denial of racism and narratives that reframe racism as "disadvantage" or dismiss Aboriginal and Torres Strait Islander lived experience.	Media, political systems
Media standards to prevent racism in all reporting	Establish and enforce national standards requiring that all media reporting, across all topics, does not create, reproduce, or exacerbate racism. These standards must be embedded within regulatory frameworks and linked to accreditation and professional accountability.	Media, journalism, communications systems, regulatory authorities, professional accreditation and standards bodies
Protect public health from commercial interests	Recognise the commercial tobacco and nicotine industry as a driver of disease and inequity; reduce and ultimately phase out the supply of commercial tobacco and nicotine products, while preventing the expansion of new nicotine markets.	Government, regulation and enforcement
Invest in community-controlled services	Recognise Aboriginal and Torres Strait Islander resistance, leadership, and community-controlled approaches as foundational to effective and evidence-based solutions. Commit to long-term, secure, and flexible funding for Aboriginal and Torres Strait Islander-led solutions and supports for people	Government, funding systems

	experiencing racism-related harms.	
Individual / Practice-level		
Personal responsibility	Require individuals and professionals to actively challenge and disrupt racism in practice, workplaces, institutions, and public discourse; intervene when racism occurs; support those affected; undertake ongoing anti-racism learning; and demonstrate accountability for contributing to culturally safe and anti-racist systems.	Individuals, professionals
Anti-racism training	Commit to ongoing anti-racism education and training; following reporting processes; advocating for fair, inclusive practices; moving beyond performative allyship and recognising racism as structural and cumulative.	Individuals, professionals
Reduce colonial load on Aboriginal and Torres Strait Islander peoples	Require systems, institutions, and workforce training to take full responsibility for cultural safety and eliminate the colonial load placed on Aboriginal and Torres Strait Islander peoples to educate, justify, or defend their lived experiences.	Everyday practice
Culturally safe environments	Embed cultural safety as a core non-negotiable, enforceable standard across training, service design, and performance evaluation, with clear accountability mechanisms for non-compliance, and explicit rejection of performative allyship.	Workplaces, institutions

SUBMITTED BY YARDHURA WALANI
8/05/2026

Fiona Cornforth,
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EXHIBIT 1:

VOICES OF RESISTANCE

A SONG. A STORY. A CALL FOR CHANGE

Click the link to watch the music video:

Voices of Resistance (explicit) Music Video - Warraay Puthu (Bad Smoke)

EXHIBIT 2:

Rights-seeking, racism, and retribution

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Rights-seeking, racism, & retribution

The right to the "highest attainable standard of physical and mental health" is embedded in the International Covenant on Economic, Social and Cultural Rights.[1] For Indigenous Peoples, this right is realised through self-determination and freedom from colonial structures. The right to self-determination is central to international human rights apparatus, including the United Nations Declaration on the Rights of Indigenous Peoples, which recognises the right of Indigenous Peoples to "be free from any kind of discrimination, in the exercise of their rights."[2] Self-determination for Aboriginal and Torres Strait Islander peoples continues to be challenged and denied by settler-colonial systems and practices that perpetuate structural violence and cause systemic inequities by preventing access to political, social, and cultural determinants of health.

Structural change, rooted in human rights and justice, is essential to dismantle these settler-colonial systems and enable Aboriginal and Torres Strait Islander peoples to reclaim the determinants of health and wellbeing. However, calls for justice and the pursuit of structural change are often met with (re)active racism, resistance, and retribution as dominant systems and groups seek to maintain and entrench power.[3,4] This has been evident in the lead up to and aftermath of the failed referendum on 14 October 2023, which sought to embed a mechanism within the Australian constitution for Aboriginal and Torres Strait Islander peoples to provide advice to government about policies affecting their lives. Leading up to the referendum, Aboriginal and Torres Strait Islander adults experienced substantial increases in interpersonal discrimination and racism, including in healthcare settings, and substantial declines in numerous aspects of wellbeing.[5] Discrimination and racism continue to be pervasive and elevated 12-months since the referendum, and the visceral effects of this are evident in many aspects of wellbeing that remain worse than levels seen in years preceding the referendum.[5]

The rejection of the referendum signalled a reinforcement of settler-colonial privilege and emboldened those seeking to uphold oppressive systems. Examples of amplified structural racism were evident soon after the referendum, including in retractions from treaty and truth-telling processes. In Queensland, where the 'no' vote was 68%, the incoming Government repealed the *Path to Treaty Act 2023 (QLD)* and abolished Queensland's Truth-telling and Healing Inquiry. This Act supported the development of a framework for treaty negotiations and established the Truth-telling and Healing Inquiry designed to report on the impacts of colonisation on Aboriginal peoples and Torres Strait Islander peoples, and help heal the trauma suffered as a result of colonisation.[6] Further examples of active resistance to Indigenous self-determination and human rights include regressive youth crime legislation introduced in Queensland and Northern Territory. These policies disproportionately target Aboriginal and Torres Strait Islander children, despite evidence that the measures are harmful and ineffective.[7] The Northern Territory Government's decision to lower the age of criminal responsibility from 12 to 10 years—a move that will almost exclusively affect Aboriginal and Torres Strait Islander children[8]—contravenes obligations under the United Nations Convention on the Rights of the Child and directly opposes recommendations of the Northern Territory Royal Commission into the Protection and Detention of Children.[9] The Queensland Government's introduction of "adult crime, adult time" under the *Making Queensland Safer Bill 2024*, egregiously required overriding the state's own human rights legislation given the incompatibility of the policy with human rights.[10] These are contemporary examples of settler-colonial tactics of dehumanising Indigenous peoples, denying Indigenous rights, and silencing truth telling. Such measures perpetuate intergenerational harms, compounding the health and wellbeing challenges faced by Aboriginal and Torres Strait Islander peoples and communities.

These actions reflect more than the aftermath of a rejected referendum—they are part of a systemic

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escalation of the oppressive power of settler-colonial structures. Aboriginal and Torres Strait Islander peoples are burdened with the dual task of resisting these systems while simultaneously enduring their harms. This dynamic entrenches a vicious cycle of inequity that prioritises settler-colonial privileges over justice, healing, and humanity. These trends are not unique to Australia but reflect a broader geopolitical climate in which efforts to address historical and ongoing structural injustices are being undermined by the rise of nationalist, populist, and conservative forces that seek to maintain colonial power.[11] For example, recent policy changes in Aotearoa New Zealand have abolished Te Aka Whai Ora (the Māori Health Authority) and wound back Māori rights in other areas; additional proposals threaten the cultural wellbeing of Māori children and diminish the rights recognised under Te Tiriti (the Treaty of Waitangi).[12] This shared context underscores the urgency of collective action to dismantle these harmful systems to uphold justice and human rights.

The health, wellbeing, and prosperity enjoyed by non-Indigenous Australians are predicated on the dispossession of Aboriginal and Torres Strait Islander peoples. This disparity is a matter of unrealised justice, wherein settler-colonial systems continue to deny the full attainment of health for Indigenous peoples. As emphasised in an Editorial in *The Lancet*: "Racism is not only about the health of particular persecuted or excluded groups—it inflicts a collective trauma on us all. The positive corollary of this fact is that lessening inequities and restoring justice can bring healing to society as a whole."[13] True justice demands the dismantling of all forms of racism. Only when racism is eliminated will the highest attainable standards of health be realised for *all* peoples, Indigenous and non-Indigenous alike. This is not simply a matter of public health; it is an urgent call for humanity, justice, and an unwavering commitment to upholding human rights.

Contributors

Conceptualisation: RL, KT, BW, CMcG, LJW, RM; Writing—original draft: BW, RL, KT; Writing—review & editing: BW, LJW, RM, RL, KT, CMcK, CS, OE, JP, CMcG, MS, FC.

Declaration of interests

The Commonwealth Department of Health and Aged Care provided funding for a project about mental health and wellbeing in the lead up to and following the Voice to Parliament Referendum; KT, RL, BW, MS, CMcK, and OE are investigators on this project. This funding does not relate to this specific paper; this paper is not funded by or endorsed or approved by the Department of Health and Aged Care. It is conducted independently from our contract with the Department. CMcG is a member of the Thiitu Tharrmay Aboriginal and Torres Strait Islander Research Reference Group. Prior to involvement in this paper, FC was a member of the Australian Government's Referendum Engagement Group in her capacity as CEO of The Healing Foundation, and was Chair of the Project Advisory Group for First Nations Consultations conducted by First Nations Co for the Australian Human Rights Commission's Anti-Racism Framework.

Acknowledgements

We gratefully acknowledge the Thiitu Tharrmay Aboriginal and Torres Strait Islander Research Reference Group for their advice and guidance in relation to this work. We acknowledge the Aboriginal and Torres Strait Islander peoples on whose lands we conduct our work, and offer our respect and gratitude to all Elders, Ancestors, Knowledge Holders, and all those who have cared for and continue to care for Country.

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EXHIBIT 3:

Research Summary: Aboriginal and Torres Strait Islander mental health and wellbeing around the Voice to Parliament Referendum

Bronwyn Wilkes (Gundungurra),[1] Emily Colonna (non-Indigenous),[1] Chris McKay (Wiradjuri)[1], Sarah Catherine Bourke (Gamilaroi, Jaru, Gidja),[1] Olivia Evans (Gomeroi),[2] Mikala Sedgwick (Gamilaraay),[1] Clinton Schultz (Gamilaraay),[3] Justyce Pengilly (Gamilaraay),[3] Fiona Conforth (Wuthathi, Maluligal),[1] Masud Hasan (non-Indigenous),[1] Benjamin Harrap (non-Indigenous),[1] Siena Montgomery (non-Indigenous),[1] Raymond Lovett (Wongaibon/Ngiyampaa)[1], Katherine A Thurber (non-Indigenous)[1]

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3. Black Dog Institute

June 2025

Content Warning

This Research Summary contains information about discrimination, racism, and mental health, which may be upsetting or distressing to read about. If you need to talk to someone, call 13YARN (13 92 76) to speak to an Aboriginal or Torres Strait Islander Crisis Support worker, or Lifeline on 13 11 14. Self-care resources and links to support services can be found here: https://yardhurawalani.com.au/information/.

Introduction

This Research Summary presents findings from a project that aimed to (1) identify health and wellbeing concerns and services required to support the Aboriginal and Torres Strait Islander population in relation to the Voice to Parliament Referendum, and (2) monitor levels of mental health and wellbeing over this period. For project details and the full report on which this summary is based, see https://yardhurawalani.com.au/mental-health-and-wellbeing-around-the-voice-to-parliament-referendum/.

This Research Summary compares levels of health and wellbeing during the first eighteen months following the Referendum vote to the period of the Referendum campaign, and to periods before public discussion around the Voice Referendum was prominent (see Figure 1), defined as follows:

- ‘Baseline’: June 2018–May 2021 (n=9,963)
- ‘Pre-Referendum period’: January 2022–January 2023 (n=2,176)
- ‘Referendum period’: 1 February 2023–14 October 2023 (n=1,286), and
- ‘Post-Referendum period: 15 October 2023–14 April 2025 (n=1,536).

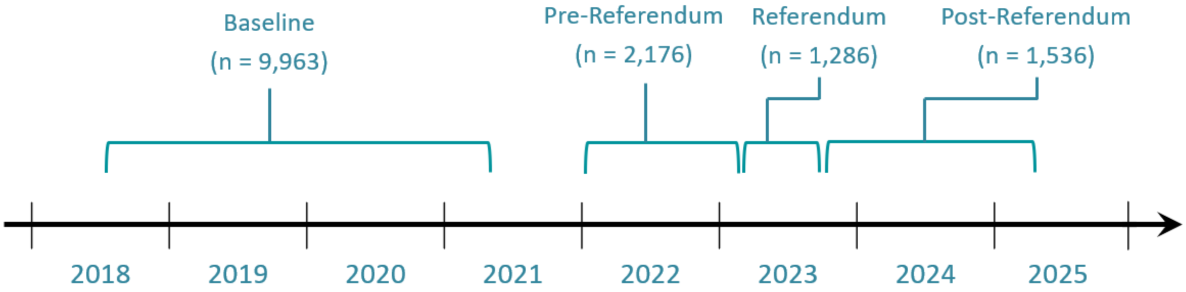

Figure 1. Study periods and participant numbers for this analysis

Data used in this analysis are from *Mayi Kuwayu: the National Study of Aboriginal and Torres Strait Islander Wellbeing*. To estimate the prevalence of outcomes in the total population of Aboriginal and Torres Strait Islander adults (aged 18 years and over), weighting was applied to the Mayi Kuwayu Study data using benchmark data from the 2021 Census (age, gender/sex, and remoteness). All changes reported are statistically significant (p-value < 0.05).

Summary of findings

Wellbeing in the lead up to the Referendum

During the Referendum period, we identified worsening in numerous wellbeing exposures and outcomes within the Aboriginal and Torres Strait Islander adult population, compared with earlier period/s. The negative changes compared with Baseline, include:

- increases in experiences of discrimination in everyday life (up 7 percentage points) and in healthcare settings (up 6 percentage points);
- increases in high/very high psychological distress (up 3 percentage points);
- decreases in measures of physical health and wellbeing (e.g. good general health down 12 percentage points);

- decreases across measures of family support (e.g. a 6 percentage point decrease in family talking with each other about things that matter); and
- decreases in some measures of self-determination (e.g. ability to get involved in community discussions down 3 percentage points).

Alongside these declines in wellbeing, vicarious racism was pervasive during the Pre-Referendum and Referendum periods, with around 70% hearing jokes and/or insulting comments about, and/or witnessing unfair treatment of, Aboriginal and/or Torres Strait Islander peoples.

Improvements, compared with Baseline, were observed in some measures of cultural connectedness. For example, there was a 6 percentage point reduction in feeling disconnected from Aboriginal and/or Torres Strait Islander culture/s in the lead up to the Referendum, compared with Baseline.

Detailed results are in Figure 2 and the sections following it.

Wellbeing in the 18 months following the Referendum

In the 18 months after the Referendum, signs of improvement were seen in feelings of life control (an increase of 4 percentage points compared with the Referendum period, to 80.6%), which returned to a level similar to Baseline (79.5%). However, alongside this, we observe a significant increase in the prevalence of anxiety in the Post-Referendum period. One-in-three (33.5%) adults had a doctor diagnosis of, or took medication for, anxiety Post-Referendum, up almost 5 percentage points from Baseline (28.9%). The prevalence of high/very high psychological distress in the Post-Referendum period (42.9%) was similar to Baseline (41.0%).

Findings from the first 18 months following the Referendum show continuing high levels—and worsening—of exposure to forms of discrimination and racism. More than half of adults reported experiences of healthcare discrimination (51.8%), a further increase of 6 percentage points from the Referendum period, representing an 11 percentage point increase from Baseline (40.4%). Experiences of vicarious racism are pervasive (78.8%) and have increased 10 percentage points since the Referendum period (69.2%). Experiences of everyday discrimination have remained elevated in the Post-Referendum period, at 74.4%, 10 percentage points above Baseline levels (64.0%).

Several measures of social and emotional wellbeing, general health, and family and community support that worsened from Baseline to the Referendum period remain worse in the Post-Referendum period. For example, good general health has dropped 13 percentage points from Baseline (to 60.3%), high happiness has dropped 5 percentage points from Baseline (to 82.9%), high life satisfaction has dropped 3 percentage points (to 67.6%) and people being accepted for who they are has dropped 8 percentage points from Baseline (to 74.2%).

We observed a concerning increase in feeling torn between cultures Post-Referendum. More than a quarter (27.8%) of adults experienced feeling torn between cultures, an increase of 7 percentage points from the Referendum period (21.0%), returning to levels higher than Baseline (22.1%) and the Pre-Referendum period (24.9%). Some of the increases in cultural connectedness observed during the Referendum period have been maintained Post-Referendum. One-in-three (34.1%) adults felt disconnected from culture in the Post-Referendum period, similar to the Referendum period (31.0%), and still lower than Baseline (37.5%).

Detailed results are in Figure 2 and the sections following it.

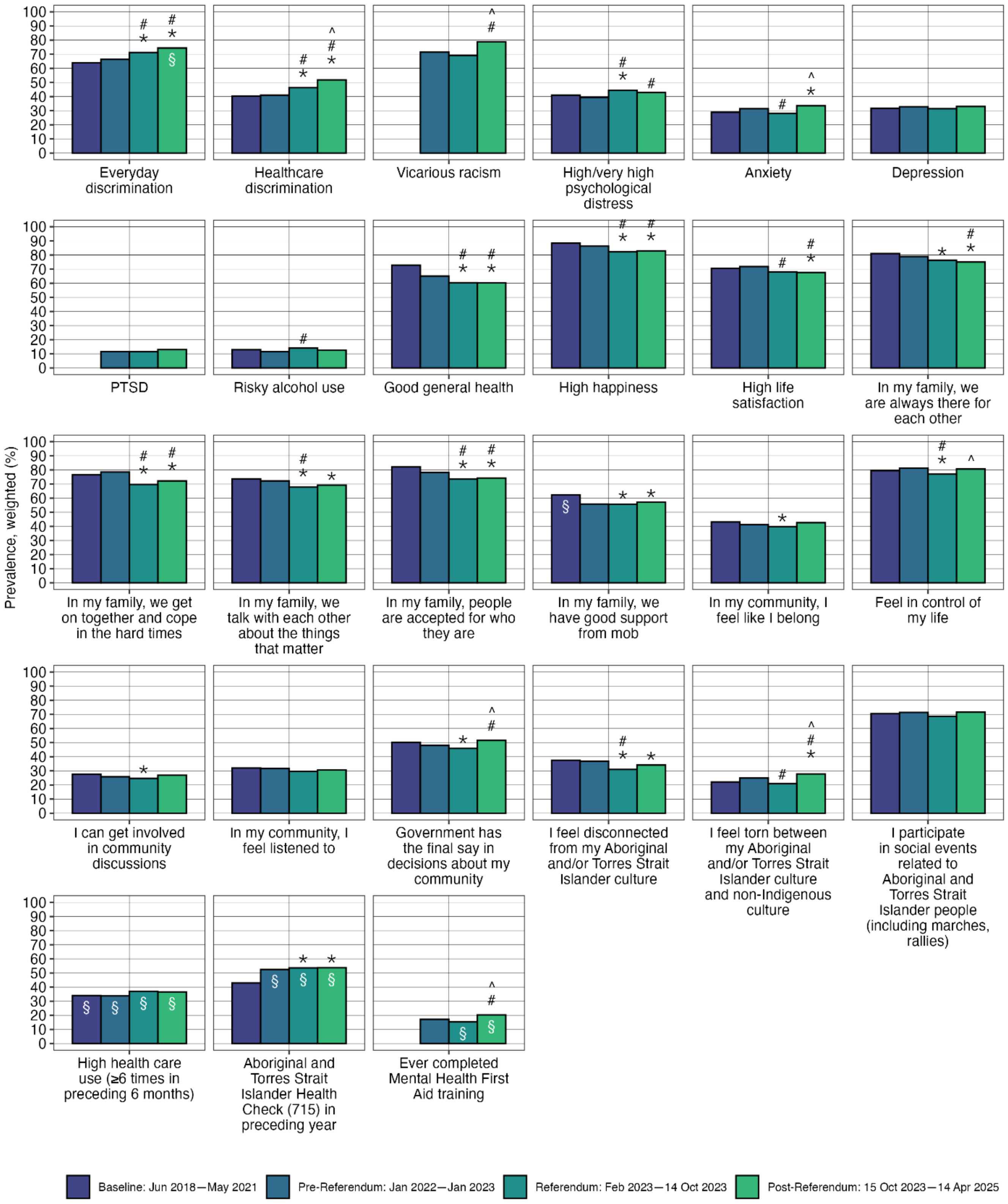

Figure 2. Weighted prevalence estimates for wellbeing outcomes over the four study periods

** significant change compared to Baseline.*

 # significant change compared to Pre-Referendum period.

^ significant change compared to Referendum period.

§ indicates that missing data prevalence exceeded 10% in the sample for the respective period; interpret with caution due to potential for bias.

Note: comparisons were not made between the Pre-Referendum period and the Baseline period.

The following outcome variables were not available in Wave 1: vicarious racism, post-traumatic stress disorder (PTSD), and mental health first aid training; accordingly, no comparisons are made to the Baseline period.

Detailed findings

Discrimination and racism

Discrimination remains widespread and elevated compared to Baseline levels, and experiences of healthcare discrimination and vicarious racism have increased since the Referendum (Figure 3). In the Post-Referendum period, an estimated 74.4% of Aboriginal and Torres Strait Islander adults had experienced everyday discrimination. This is similar to the percentage in the Referendum period (71.2%) and represents an increase of about 10 percentage points from the Baseline period (64.0%). This corresponds to an estimated 51,000 additional adults having experienced everyday discrimination in the Post-Referendum period compared to Baseline.

In the Post-Referendum period, over half (51.8%) of Aboriginal and Torres Strait Islander adults had experienced discrimination in healthcare settings, which represents an increase compared to both the Referendum period (46.3%) and the Baseline period (40.4%). The overall increase corresponds to an estimated 56,000 additional Aboriginal and Torres Strait Islander adults experiencing discrimination in healthcare settings in the Post-Referendum period compared to Baseline.

From Wave 2 onwards, the Mayi Kuwayu Study has measured aspects of vicarious racism, including the experience of hearing jokes or insulting comments about Aboriginal and Torres Strait Islander peoples, and witnessing unfair treatment of Aboriginal and Torres Strait Islander peoples. Experiencing vicarious racism was already pervasive in both the Pre-Referendum (71.5%) and Referendum (69.2%) periods, and became more so in the Post-Referendum period (78.8%). This corresponds to an estimated 36,000 additional Aboriginal and Torres Strait Islander adults experiencing vicarious racism in the Post-Referendum period compared to the Pre-Referendum period. No data are available for this measure at Baseline.

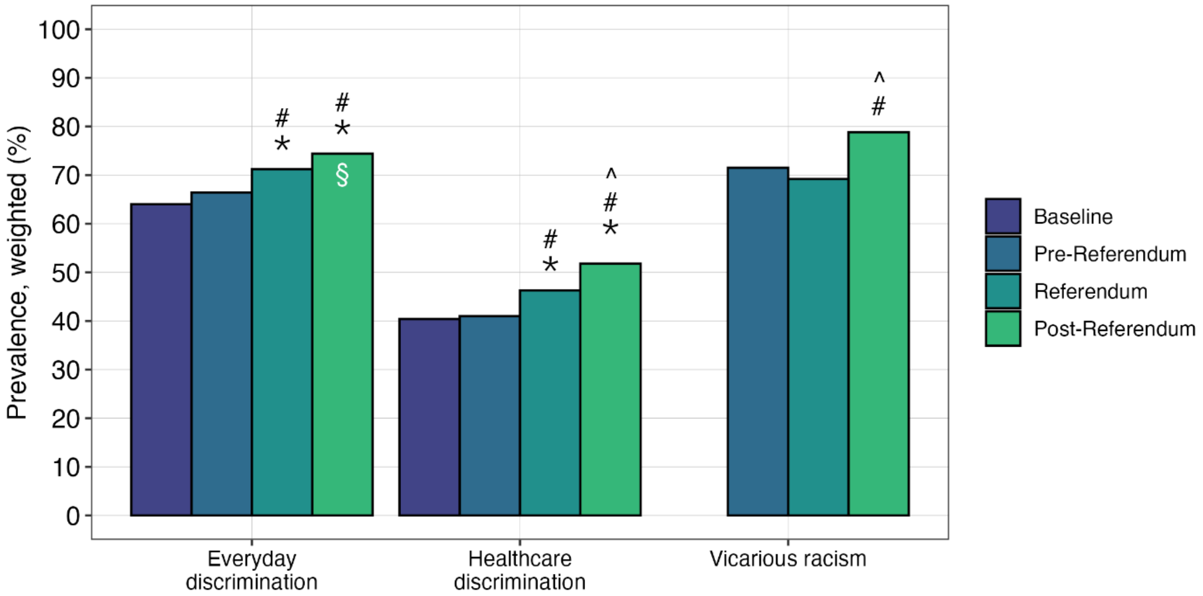

Figure 3. Weighted prevalence estimates for discrimination and racism variables over the four study periods.
** indicates significant change compared with Baseline.*
 # indicates significant change compared with Pre-Referendum period.
^ indicates significant change compared with Referendum period.
§ indicates that missing data prevalence exceeded 10% in the sample for the respective period; interpret with caution due to potential for bias.
Note: comparisons were not made between the Pre-Referendum period and the Baseline period.
The vicarious racism measure was introduced in Wave 2, hence no data are available for the Baseline period (which uses Wave 1 data).

Health and wellbeing

Psychological distress remains common and elevated compared to the Pre-Referendum period, and anxiety is elevated compared to both Baseline and the Referendum period (Figure 4). During the Post-Referendum period, 42.9% of Aboriginal and Torres Strait Islander adults experienced high or very high psychological distress. This is similar to the percentage in the Referendum period (44.4%) and Baseline (41.0%), but represents an increase compared to the Pre-Referendum period (39.5%). An estimated 17,000 additional Aboriginal and Torres Strait Islander adults experienced high or very high psychological distress in the Post-Referendum period compared to the Pre-Referendum period.

During the Post-Referendum period, 33.5% of Aboriginal and Torres Strait Islander adults had a doctor diagnosis of, and/or took medication for anxiety. This is higher than at Baseline (28.9%) and the Referendum period (28.1%), noting the prevalence during the Referendum period was lower than in the Pre-Referendum period (31.4%). Anxiety prevalence in the Post-Referendum period was over 4 percentage points above Baseline, representing an estimated 22,000 additional adults with anxiety.

Our measure of psychological distress (the MK-K5) reflects current symptoms of anxiety and depression (i.e. in the past four weeks). High/very high levels of psychological distress based on the MK-K5 may indicate a risk of anxiety, and therefore would support further assessment, but does not represent a clinical diagnosis.[1] In contrast, a diagnosis of anxiety would generally require consistent symptoms over a longer period (e.g. six months), and assessment by a health professional. The lag in increased prevalence of diagnosed anxiety could also reflect wait times for seeing a doctor. Similarly, a diagnosis of depression or PTSD would also require access to a doctor and/or a psychologist.

During the Post-Referendum period, 33.0% of Aboriginal and Torres Strait Islander adults had a doctor diagnosis of, and/or took medication for, depression, consistent with earlier time points: 31.7% at Baseline, 32.8% in the Pre-Referendum period, and 31.4% during the Referendum period.

The prevalence of post-traumatic stress disorder (PTSD) was similar across periods: 11.6% in the Pre-Referendum period, 11.5% in the Referendum period, and 13.0% in the Post-Referendum period. No data were collected on PTSD in the Baseline period.

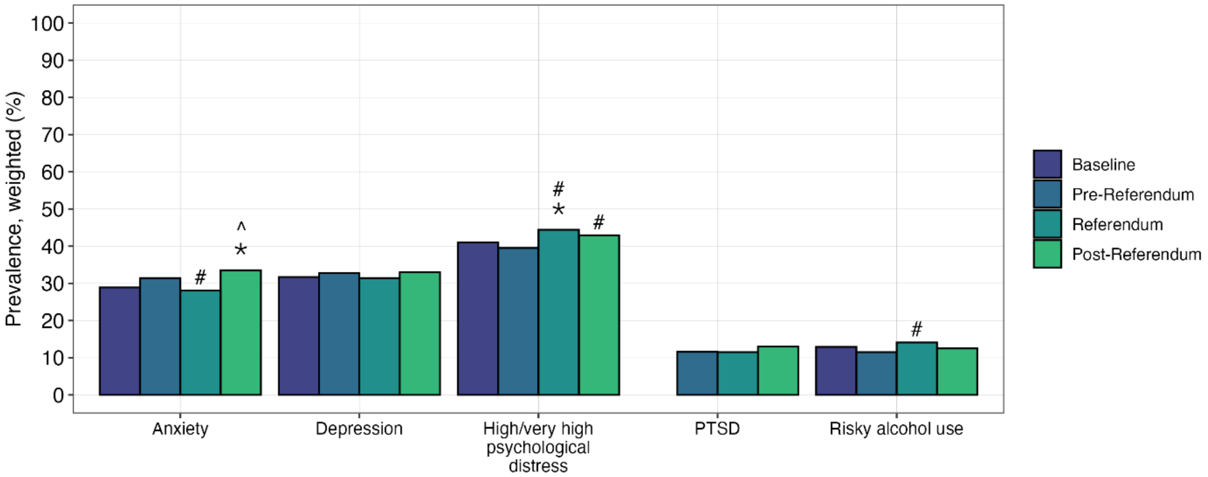

Figure 4. Weighted prevalence estimates for selected mental health & physical health variables over the four study periods.
** indicates significant change compared with Baseline.*
 # indicates significant change compared with Pre-Referendum period.
^ indicates significant change compared with Referendum period.
Note: comparisons were not made between the Pre-Referendum period and the Baseline period.
PTSD measure was introduced in Wave 2, hence no data are available for Baseline period (which uses Wave 1 data).

Alcohol consumption is sometimes used as a coping mechanism in response to stress. Alcohol use was included as a variable in this analysis because some focus group participants (see Report 1 in this series) mentioned that alcohol may be used as a way to cope with stressors relating to the Referendum. In this project, risky alcohol use was defined as consuming six or more drinks per day on a weekly or more frequent basis. The estimated prevalence of risky alcohol use was 12.9% at Baseline, 11.5% in the

Pre-Referendum period, 14.1% in the Referendum period, and 12.5% in the Post-Referendum period.

Levels of general health have substantially dropped since Baseline; levels of happiness are high, but remain lower than at Baseline (Figure 5). An estimated 60.3% of Aboriginal and Torres Strait Islander adults experienced good general health in the Post-Referendum period. This represents a 13 percentage point decline from Baseline (72.8%) and is similar to the prevalence in the Referendum period (60.4%). This corresponds to an estimated 62,000 fewer Aboriginal and Torres Strait Islander adults experiencing good general health during the Post-Referendum period compared to Baseline.

The prevalence of high happiness in the Post-Referendum period (82.9%) was lower than in the Baseline (88.4%) and Pre-Referendum (86.3%) periods and similar to levels during the Referendum period (82.3%). This represents an estimated 27,000 fewer Aboriginal and Torres Strait Islander adults experiencing high happiness during the Post-Referendum period compared to Baseline.

The prevalence of high life satisfaction in the Post-Referendum period was 67.6%, which was lower than the Pre-Referendum period (71.8%) and Baseline (70.6%), and similar to the Referendum (68.0%) period. This represents an estimated 15,000 fewer Aboriginal and Torres Strait Islander adults experiencing high life satisfaction during the Post-Referendum period compared to Baseline.

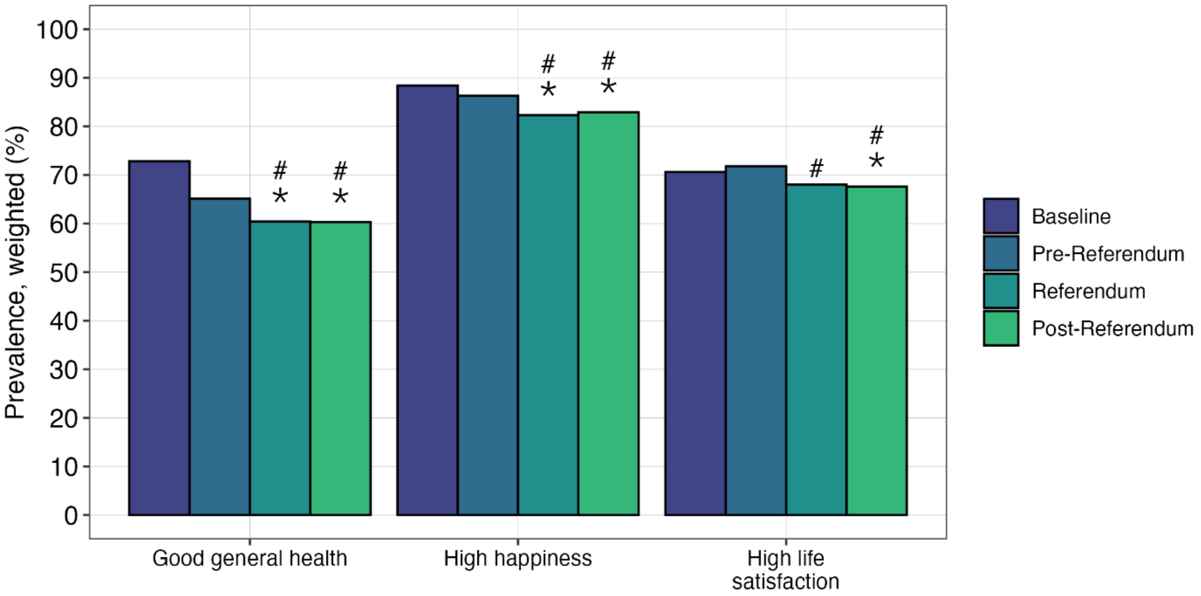

Figure 5. Weighted prevalence estimates for general health, happiness and life satisfaction variables over the four study periods.

** indicates significant change compared with Baseline.*

 # indicates significant change compared with Pre-Referendum period.

^ indicates significant change compared with Referendum period.

Note: comparisons were not made between the Pre-Referendum period and the Baseline period.

Family and community support

Family support is high, but many measures remain lower than at Baseline (Figure 6). Across the measures of family and community support examined, we did not detect any significant differences between the Post-Referendum period and the Referendum period. In the Post-Referendum period it was less common for families to get on together and cope in hard times (72.2%), compared to both the Baseline (76.5%) and the Pre-Referendum (78.5%) periods. Similarly, Post-Referendum, there was a lower prevalence of being there for each other (75.0%) compared to the Baseline (81.0%) and the Pre-Referendum (78.9%) periods. There was also a lower prevalence of people being accepted for who they are in the Post-Referendum period (74.2%) compared to the Baseline period (82.1%) and the Pre-Referendum period (78.2%).

In the Post-Referendum period compared to Baseline, there remained a lower prevalence of talking with each other about the things that matter (69.2% compared to 73.6%) and having good support from mob

(57.1% compared to 62.3%).

There was no significant change in the percentage of people who felt like they belonged in their Aboriginal and Torres Strait Islander community, which remained around 40% across survey periods.

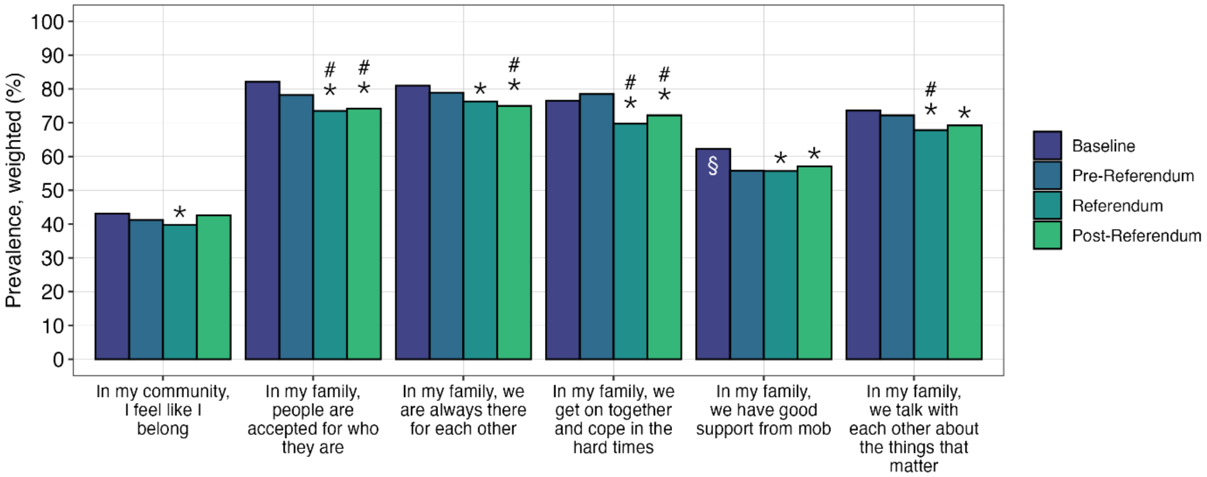

Figure 6. Weighted prevalence estimates for family and community support variables over the four study periods.

** indicates significant change compared with Baseline.*

 # indicates significant change compared with Pre-Referendum period.

^ indicates significant change compared with Referendum period.

Note: comparisons were not made between the Pre-Referendum period and the Baseline period.

§ indicates that missing data prevalence exceeded 10% in the sample for the respective period; interpret with caution due to potential for bias.

Self-determination

All included measures of self-determination are similar to Baseline levels (Figure 7). During the Post-Referendum period, 80.6% of Aboriginal and Torres Strait Islander adults felt in control of their lives. This prevalence was consistent with levels at Baseline (79.5%), and the Pre-Referendum period (81.3%), and higher than levels during the Referendum period (77.0%) (which was lower than Baseline and the Pre-Referendum period). The percentage of Aboriginal and Torres Strait Islander adults who felt they could get involved in Aboriginal and Torres Strait Islander community discussions was 26.9% in the Post-Referendum period which was similar to the Baseline (27.6%), Pre-Referendum (25.8%), and Referendum (24.7%) periods (the Referendum period was lower than Baseline).

The prevalence of feeling listened to in community was similar across periods: 32.0% at Baseline, 31.7% in the Pre-Referendum period, 29.6% in the Referendum period, and 30.6% in the Post-Referendum period. The prevalence of Aboriginal and Torres Strait Islander adults who felt that government has the final say in Aboriginal and Torres Strait Islander community decisions was 51.6% during the Post-Referendum period, which was an increase from the Referendum period low of 45.9% and the Pre-Referendum level of 48.0%, but similar to the Baseline level of 50.2%.

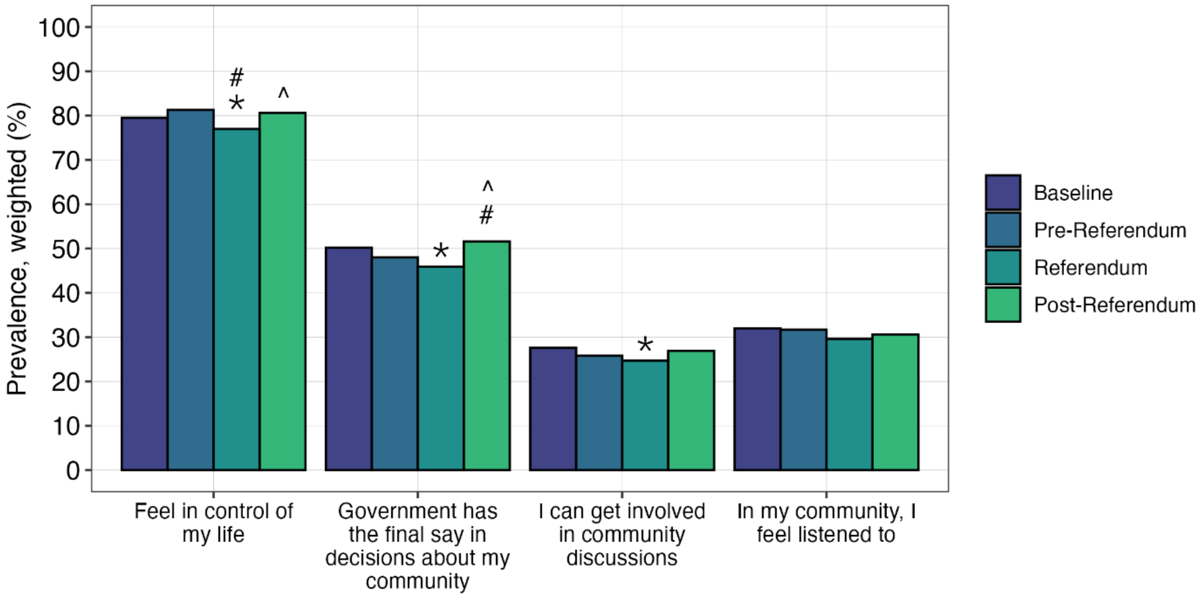

Figure 7. Weighted prevalence estimates for self-determination variables over the four study periods.
** indicates significant change compared with Baseline.*
 # indicates significant change compared with Pre-Referendum period.
^ indicates significant change compared with Referendum period.
Note: comparisons were not made between the Pre-Referendum period and the Baseline period.

Cultural connectedness

Feeling torn between cultures is increasing, but connection to Aboriginal and/or Torres Strait Islander culture is better than at Baseline (Figure 8). Some measures of Aboriginal and Torres Strait Islander cultural connectedness had improved during the Referendum period compared to earlier period/s; some of these improvements were maintained but others were not.

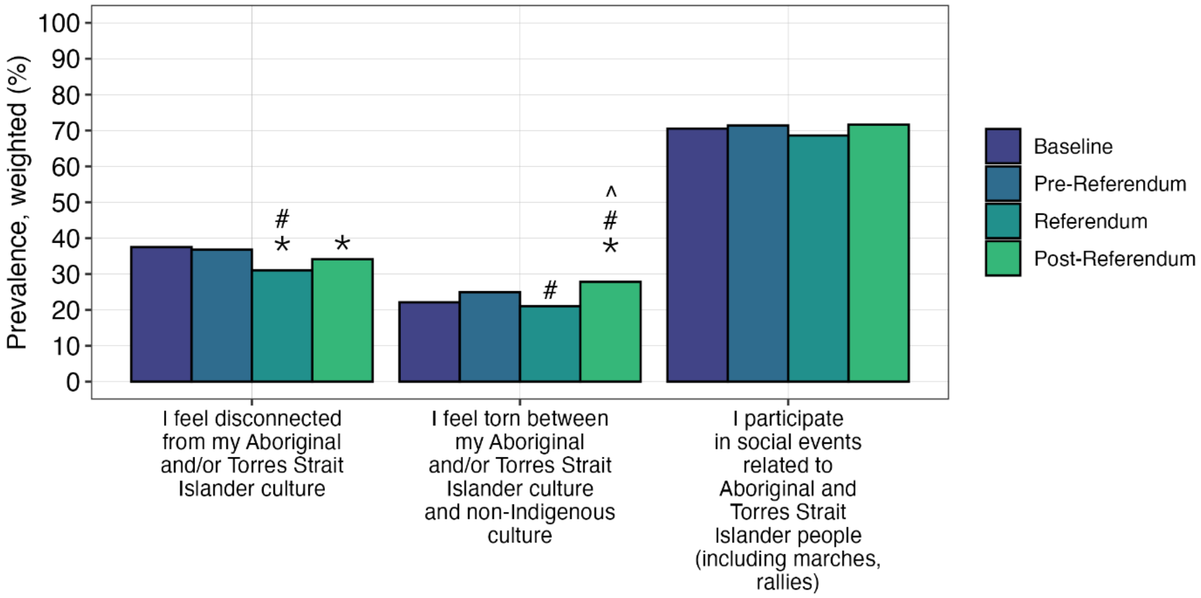

Figure 8. Weighted prevalence estimates for cultural connectedness variables over the four study periods.
** indicates significant change compared with Baseline.*
 # indicates significant change compared with Pre-Referendum period.
^ indicates significant change compared with Referendum period.
Note: comparisons were not made between the Pre-Referendum period and the Baseline period.

It was less common to feel disconnected from Aboriginal and/or Torres Strait Islander cultures during the Referendum period (31.0%) compared to Baseline (37.5%), indicating improvements in connectedness to

culture. In the Post-Referendum period the prevalence of feeling disconnected was 34.1%, which was similar to the Referendum and Pre-Referendum period, and lower than levels observed in the Baseline period.

During the Post-Referendum period, the percentage of Aboriginal and Torres Strait Islander adults who felt torn between their Aboriginal and/or Torres Strait Islander cultures and non-Indigenous culture was higher in the Post-Referendum period (27.8%) than in the Referendum (21.0%), Pre-Referendum (24.9%), and Baseline (22.1%) periods.

Participation in social events related to Aboriginal and Torres Strait Islander peoples has remained high. More than two-thirds of Aboriginal and Torres Strait Islander adults participated in these events across the Baseline (70.5%), Pre-Referendum (71.4%), Referendum (68.6%), and Post-Referendum (71.6%) periods.

Health service use

Comprehensive health checks and high healthcare service use remain common (Figure 9). An estimated 36.6% of Aboriginal and Torres Strait Islander adults accessed healthcare services monthly or more frequently during the Post-Referendum period, consistent with 34.0% in the Baseline period, 33.8% in the Pre-Referendum period, and 36.9% in the Referendum period.

The Mayi Kuwayu Study survey collects data on participants’ completion of an Aboriginal and Torres Strait Islander Health Check (“715 Health Check”) within the last year. During the Post-Referendum period, an estimated 53.7% had recently completed a Health Check. This was an increase of almost 11 percentage points compared to Baseline (42.9%), and consistent with levels during the Referendum period (53.6%) and Pre-Referendum period (52.5%).

An estimated 20.3% of Aboriginal and Torres Strait Islander adults had completed Mental Health First Aid training during the Post-Referendum period. This was an increase compared to the Referendum period (15.4%) and the Pre-Referendum period (17.2%). No data were available for this measure at Baseline.

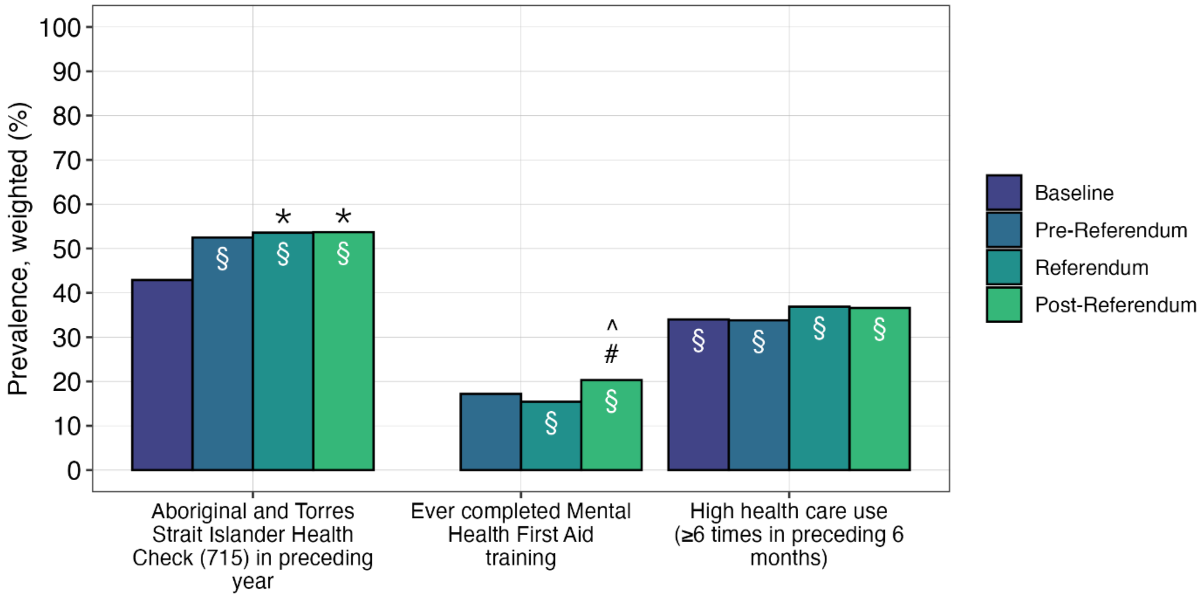

Figure 9. Weighted prevalence estimates for service use variables over the four study periods.

** indicates significant change compared with Baseline.*

 # indicates significant change compared with Pre-Referendum period.

^ indicates significant change compared with Referendum period.

§ indicates that missing data prevalence exceeded 10% in the sample for the respective period; interpret with caution due to potential for bias.

Note: comparisons were not made between the Pre-Referendum period and the Baseline period.

The Mental Health First Aid training measure was introduced in Wave 2, hence no data are available for the Baseline period (which uses Wave 1 data).

What do these results mean?

Experiences of discrimination, general health, happiness, and family and community wellbeing remain worse Post-Referendum compared to Baseline. Experiences of healthcare discrimination, vicarious racism and doctor-diagnosed anxiety have continued to increase from levels observed during the Referendum period. Whereas aspects of health and wellbeing remain strong in the face of escalating stressors —a testament to the strength of Aboriginal and Torres Strait Islander peoples and cultures—continued pressure on protective factors such as family and community support and strong connection to culture threatens to erode health and wellbeing. In addition to action against all forms of racism and discrimination, the results of this project highlight the need for additional measures to support self-determination and holistic health and wellbeing for Aboriginal and Torres Strait Islander peoples, families, and communities.

This report's findings are consistent with concerns expressed by Aboriginal and Torres Strait Islander participants in focus groups conducted earlier in this project (Report and summary factsheets available online: https://yardhurawalani.com.au/mental-health-and-wellbeing-around-the-voice-to-parliament-referendum/). Our findings on discrimination and racism align with reports from 13YARN, a national First Nations crisis support service. Aboriginal and/or Torres Strait Islander people's calls to 13YARN increased by 40% during the Referendum campaign; Post-Referendum, over a quarter (26%) of calls have been from people experiencing distress caused by racism.[2] Our findings are also consistent with annual reporting from the Call It Out First Nations Racism Register, in which one in five validated reports of racism during the 2023–24 reporting period specifically mentioning the Voice and/or the Referendum.[3]

The cross-sectional design of this project does not permit attribution of the results to any particular cause, however the discourse around the Referendum is likely to have contributed to the observed increases in racism, discrimination, and associated declines in health outcomes. It is not possible to disentangle other factors that may have contributed to the results observed, and there is no shortage of events and discourses that have negatively impacted—and continue to negatively impact—the wellbeing of Aboriginal and Torres Strait Islander peoples. Settler-colonial violence—in physical, structural, and discursive forms—continues to be pervasive internationally and in Australia, including: violent conflict in Gaza;[4] Indigenous deaths in custody;[5] and racist policies and positions being at the forefront of political debate in election campaigns in the US in 2024,[6] in Aotearoa New Zealand in 2024,[7–9] and in Australia at state/territory and federal levels in 2024 and 2025.[10–12] For example, the Queensland and Northern Territory elections in 2024 saw escalations in structural racism via regressive youth crime legislation and associated public discourse (e.g. "adult crime, adult time"[13]), repeal of the *Path to Treaty Act 2023 (QLD)* and abolishing of Queensland's Truth-telling and Healing Inquiry. Backlash against Welcome to Country ceremonies and Acknowledgements of Country has been prominent,[14,15] promoted by some politicians,[16,17] and comprised part of the election platform for the Trumpet of Patriots party.[18] Regardless of their causes, the observed increasing racism prevalence and declines in aspects of wellbeing are of deep concern.

The racism, discrimination, and associated health harms observed over the Referendum period, and since, do not represent justifications for not pursuing structural change designed to eliminate racism or address injustices suffered by Aboriginal and Torres Strait Islander peoples. Justice must be pursued, as this is a fundamental determinant of the health and wellbeing of Aboriginal and Torres Strait Islander peoples. Robust commitments to truth-telling and respectful discourse by politicians and media are fundamental for processes of structural change and enactment of Indigenous rights to proceed with minimal harm.

The results of this project underscore the urgent need for action against all forms of racism and discrimination. Ongoing monitoring is but one part of this. While monitoring can enable visibility and validation for the lived experiences of Aboriginal and Torres Strait Islander peoples, meaningful action and accountability is required from governments, politicians, media, and public organisations. There is no shortage of advice from Aboriginal and Torres Strait Islander peoples on what such action should look like.[19–28]

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EXHIBIT 4:

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Australia's new lung cancer screening program has chosen simplicity over equity, and we're concerned

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Australia's lung cancer screening program launched on July 1, and marks real progress and opportunity.

It aims to reduce the number of people dying from lung cancer by offering regular low-dose CT scans to people who smoke, and those who have quit. The aim is to detect and treat cancer early before it has spread.

But the program's design may further disadvantage Aboriginal and Torres Strait Islander peoples, who are disproportionately affected by lung cancer.

So Australia's first new cancer screening program in almost 20 years risks entrenching health inequities rather than addressing them.

Lung cancer is a particular burden

Lung cancer is the most common cancer and the leading cause of cancer death for Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander peoples are 2.1 times more likely to be diagnosed with lung cancer, and 1.8 times more likely to die from it, compared with non-Indigenous Australians.

Aboriginal and Torres Strait Islander peoples are also more likely to be diagnosed with lung cancer at a younger age than non-Indigenous Australians.

Understanding the broader context of lung cancer risk among Aboriginal and Torres Strait Islander peoples is crucial.

Aboriginal and Torres Strait Islander peoples have been paid in tobacco rations rather than wages up until the 1960s, excluded from economic and health systems, and targeted by tobacco industry marketing.

Indigenous-led tobacco control and quit-smoking programs, such as the Tackling Indigenous Smoking program, have made significant progress in reducing smoking rates. Indigenous communities are leading the resistance against tobacco industry harms.

However, Aboriginal and Torres Strait Islander peoples face major barriers to lung cancer screening. This is particularly in rural and remote areas where access to GPs, radiology services and culturally safe care is limited.

Lung cancer screening should account for this

Initially, the lung cancer screening program was designed with a lower screening age for Aboriginal and Torres Strait Islander peoples – 50 years compared with 55 years for non-Indigenous Australians. This made sense in the face of the earlier and higher risk of lung cancer.

However, the Medical Services Advisory Committee, the body responsible for assessing applications for public funding, removed this risk-based distinction. Now there's a general age eligibility of 50–70 years.

This is a shift from equity (fairness) to equality (sameness). In health, treating everyone equally deepens inequities.

By contrast, many public health programs strive for equity and reflect the differing needs of Aboriginal and Torres Strait Islander peoples. For instance, heart health checks and many vaccines are offered to Aboriginal and Torres Strait Islander peoples at a younger age.

There are also possible consequences of lowering the screening age for non-Indigenous Australians from 55 (as originally intended) to 50. Cancer Australia's report warned this would not provide a favourable balance of benefits and harms, nor would it be cost-effective.

In this lower-risk population, this could increase the likelihood of detecting slow-growing lung nodules unlikely to cause harm. This can lead to unnecessary tests and procedures, anxiety, psychological distress, overtreatment and even harm.

While Aboriginal and Torres Strait Islander peoples can also experience these potential harms, the higher risk of lung cancer earlier means the potential benefit from early detection outweighs these risks.

Let's call it for what it is – structural racism

Current eligibility criteria expands the eligibility for lower risk groups, yet it ignores Aboriginal and Torres Strait Islander peoples' higher risk and cumulative impacts of remoteness, limited access to health services and other health conditions.

This decision significantly increases the number of people accessing the program. While this may appear equal on the surface, it risks a misallocation of limited health system resources, particularly in an already overstretched health system.

That's a clear example of structural racism – when policies that seem neutral actually uphold longstanding inequities, and reinforce disadvantages.

This has parallels with concerns raised in the United States. Screening guidelines there have been criticised for failing to account for higher rates of lung cancer in African Americans.

What should we do next?

If we're serious about a commitment to equity in cancer outcomes – as outlined in the Australian Cancer Plan and Aboriginal and Torres Strait Islander Cancer Plan – we must ensure screening policies do not inadvertently widen inequities.

We must revisit who's eligible for screening and how eligibility is determined. This may mean not only considering age and smoking history, but other factors such as a family history of cancer.

It might also mean predicting lung cancer risk using models such as the PLCOm2012 risk prediction model. However, this particular model has not been validated in Aboriginal and Torres Strait Islander peoples, which needs to be a priority.

Instead, the Medical Services Advisory Committee has prioritised the same screening age for all – administrative simplicity over this more sensitive way of assessing risk.

We must prioritise Aboriginal and Torres Strait Islander peoples on screening waitlists and follow-up, and strengthen the cultural safety of services.

Exhibity

We must ensure robust data collection and reporting to evaluate the screening program. Evaluation needs to assess if the program delivers equitable access and outcomes, as well as delivering on effectiveness, safety and cost.

All these actions are essential to address the higher burden of lung cancer among Aboriginal and Torres Strait Islander peoples and uphold equity and the right to health over administrative simplicity.

This is the final article in the 'Finding lung cancer' series, which explores Australia's first new cancer screening program in almost 20 years.

If you need support to quit smoking, see your doctor or call Quitline on 13 78 48.

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